

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on August 30, 2004.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the physical therapy evaluation, whirlpool, therapeutic exercises, and ultrasound therapy were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On September 23, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

- CPT Code 99214 for dates of service 10/17/03 and 11/06/03 denied as "N". Per Rule 134.202(b), review of the office notes submitted for the dates of service in dispute do not meet the documentation criteria set forth by the CPT Code descriptor as listed in Ingenix EncoderPro. Therefore, reimbursement is not recommended.
- CPT Code 99080-73 for date of service 11/07/03 denied as "N". In accordance with Rule 129.5, the requestor did not submit a copy of the TWCC-73; therefore, reimbursement is not recommended.
- CPT Code 99455 for date of service 11/18/03 for date of service 11/18/03 denied as "N". Per Rule 134.202(e)(6)(F) the treating doctor is required to review the certification of MMI. The treating doctor attached modifier "VR" to indicate a review of the report only. Per the HCFA 1500 the modifier was not attached to the CPT code billed. The submitted relevant information for this date of service does not document the review of the report; therefore, reimbursement is not recommended.

The above Findings and Decision is hereby issued this 4th day of November 2004.

Marguerite Foster  
Medical Dispute Resolution Officer  
Medical Review Division

MF/mf

Enclosure: IRO Decision



7600 Chevy Chase, Suite 400  
Austin, Texas 78752  
Phone: (512) 371-8100  
Fax: (800) 580-3123

## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** October 26, 2004

**To the Attention Of:**

TWCC  
7551 Metro Center Drive, Suite 100, MS-48  
Austin, TX 78744-16091

**RE: Injured Worker:**

**MDR Tracking #:** M5-05-0017-01

**IRO Certificate #:** 5242

Forté has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by an occupational medicine reviewer who is board certified in occupational medicine and who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

**Submitted by Requester:**

- Various TWCC request forms
- Table listing disputed services
- Explanation of benefits payment form
- Patient registration information
- Letter from P. Hunnicutt, St. Joseph Regional Health Center dated 9/27/04
- Records from St. Joseph Regional Health Center and Outpatient Rehabilitation and Sports Medicine Center

- Outpatient visit with Dr. Lobb
- Clinic records from St. Joseph Occupational Health Services
- Report of right hand X-ray
- Report of MRI of right upper extremity

#### **Submitted by Respondent:**

- Various TWCC request forms
- Records from St. Joseph Regional Health Center and Outpatient Rehabilitation and Sports Medicine Center
- Outpatient visit with Dr. Lobb
- Clinic records from St. Joseph Occupational Health Services
- Report of right hand X-ray
- Report of MRI of right upper extremity
- Reports of visits with Barry Veazey, M.D.
- Reports of visits with David Muehe, P.A.
- Report of DDE with Peter Foox, M.D.
- Summary of injury from Medical Business Management Services

#### **Clinical History**

\_\_\_ is a 41 year old woman who was reportedly injured on \_\_\_ while working as a custodian. It is reported that she was pulling a paper towel when the metal dispenser fell from the wall striking the right wrist. She caught the dispenser but noted pain in the wrist and palm. She was reportedly seen at Scott & White. She was diagnosed with a contusion. On 6/24/03 she was seen at St. Joseph Occupational Health Clinic. X-rays of the wrist on 7/1/03 were interpreted as “no acute fracture” and she received conservative treatment with ice, rest, home exercise, light duty, and non-steroidal anti-inflammatory medication. A week later she was treated with steroids and a splint. She is reported to have had an adverse reaction to steroids. On 7/18/03 she was examined by Dr. Veazey (orthopedics) and an MRI of the wrist was ordered. This was performed on 8/6/03 and revealed no acute changes. She received 6 weeks of physical therapy beginning on 7/9/03, and 4 weeks of occupational therapy beginning on 8/26/03. A nerve conduction study was performed on 7/18/03 and considered to reveal mild right median neuropathy at the wrist. In October she was returned to full duty on a trial basis, but she was later again placed on restricted duty. She was evaluated by Dr. Lobb (pain management) and felt to be at maximum medical improvement on 11/5/03. She was assigned 4% whole body impairment. On 1/23/04 Dr. Foox performed a designated doctor examination (DDE) and agreed that the patient had reached maximum medical improvement from her wrist contusion on 11/5/03. He calculated 7% whole person impairment.

#### **Requested Service(s)**

I have been asked to comment on the medical necessity of physical therapy provided between 9/29/03 and 12/1/03, which included physical therapy evaluation (97001), whirlpool treatment (97022), therapeutic exercises (97110), and ultrasound therapy (97035).

**Decision**

I agree with the insurance carrier that the requested services were not medically necessary.

**Rationale/Basis for Decision**

This woman had a careful evaluation of wrist and hand complaints after minor trauma. X-rays and an MRI of the wrist failed to reveal acute bone injury. Nerve conduction studies failed to explain her symptoms. She received prolonged treatment with physical therapy, medications, splinting, and orthopedic evaluation. Records suggested consideration of several diagnoses including contusion, sprain, de Quervain's tenosynovitis, and carpal tunnel syndrome. Treatment of the patient's symptoms was appropriate, employing all recommended modalities including non-steroidal anti-inflammatory drugs medication, work duty modification, ice, and physical therapy. The median requirement for modified duty from wrist sprain is 10 days while tenosynovitis averages 15 days. Prolonged physical therapy is not recommended. This patient was prescribed lengthy course of physical therapy that began about 2 weeks after her injury, and a course of occupational therapy was instituted 2 months after her injury, and a final course of physical therapy was begun 3 months after her injury and continued even after she was declared to be at maximum medical improvement. I agree with the insurance carrier that the second course of physical therapy was not medically necessary.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 26th day of October 2004.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder